CBP-156A (r. 12/12)

*Probationary Employees and Non-Benefit Employees as defined under NCO#350.237 are **not** eligible for Injury Pay.*

CITY OF MILWAUKEE
DEPARTMENT OF EMPLOYEE RELATIONS
ABSENCE DUE TO WORK RELATED INJURY

APPLICATION FOR INJURY PAY or WORKER'S COMPENSATION BENEFIT ☐

Personal Details of Injured Person		
Name *(First, Last):*		**Instructions:** When you have an on the job injury the following information must be submitted each time you apply for Injury Pay or Worker's Compensation Benefits. **1.** A statement from the medical provider indicating that the absence was medically necessary due to the work injury. **2.** A statement from the medical provider indicating that the employee was unable to work during the absence. **3.** If applicable, the medical restrictions upon return to work and the duration of those restrictions. **Note: Assume EB-49 has been submitted to DER.**
Address:		
Dept/Div:		
Employee ID #:		
Job Title:		

Period Absent from Work: *(If less than one full working day, complete Line 2 below)*

1. Number of working days absent:

	Month	Day	Year		Month	Day	Year
From:				To:			

2. Number of hours absent *(partial day absence)*:

	Month	Day	Year				
From:				:	To:		:

Accident/Injury Details

Date of Accident:	
Body Part(s) Injured:	

Did you provide the required notification of the absence in accordance with your departmental policy? ☐ Yes ☐ No

To whom reported:	

Did you receive medical attention from a medical provider during the above period? ☐ Yes ☐ No
Provider's Name:
Address/Telephone Number:

I HEREBY CERTIFY THAT:

☐ I was unable to perform the duties of my position during the period of the absence.
☐ My absence was due to the work injury and because of a medical reason.
☐ I remained at home during the full period of illness, except for visits to the doctor. *If answer is no, please explain below:*

If I should lose time from work as a result of an on-the-job injury and I have checked the Worker's Compensation Benefit box above, or if I have exhausted my bank of injury hours, this is to certify that I hereby elect the following option:

☐ Option 1: Elect to take my accumulated Sick Leave *(if available).*
☐ Option 2: Elect to take my accumulated Vacation *(if available).*
☐ Option 3: Do not wish to elect Sick Leave or Vacation. *(Contact your Payroll Dept. regarding how your benefits may be affected.)*
☐ Option 4: Elect to take my accumulated Compensatory Time.

***Note:** All elections involving the use of Earned Sick or Vacation Leave are subject to their availability at the time of the incident.*

- **I understand that once I elect an option, that the election shall be irrevocable as to each individual incident.**
- **I certify that the above statements are true and correct. I understand that providing false information will be considered cause for disciplinary action, up to and including discharge.**

Employee Signature: *Date:*

THIS SECTION FOR DEPARTMENTAL APPROVAL

I reviewed this application for accuracy and completeness.

Signature: *Date:*